Illinois Department of Healthcare and Family Services

Managed Care Manual for Medicaid Providers

January 2016

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Intent of this Manual:

This manual contains helpful information regarding the Medicaid managed care program for Providers enrolled in Medicaid. Please be advised that this manual is not intended to supersede, modify, or replace any policies, guidelines, or other Provider handbooks applicable to Providers in the Medical Assistance Program under the Fee-For-Service payment system. Further, this handbook does not alter or supersede any managed care contractual obligations, duties, or requirements between Providers and Health Plans or between the Illinois Department of Healthcare and Family Services and Health Plans. Further guidance regarding the Medicaid Fee-For-Service program can be found in the HFS Provider Handbooks.

Chapter 1 Managed Care Overview

1.10 Introduction

In order to carry out the mission of the Department of Healthcare and Family Services to improve the health of Medicaid Participants by providing access to, and coordination of, quality health care, HFS is reforming the systems that deliver medical care to participants. This mission includes providing a Primary Care Provider (PCP) for every participant; maintaining continuity of care with that PCP; creating comprehensive networks of care around participants including primary care, specialists, hospitals and behavioral care; and offering care coordination to help participants with complex needs navigate the healthcare system pursuant to the Medicaid reform law (*Public Acts 096-1501* and *97-689)* and the federal Affordable Care Act *(Public Law 111-148).* Risk and performance is tied to reimbursement in order to transform the Medicaid healthcare delivery system to one with a focus on improved health outcomes.

HFS has completed the roll-out of mandatory care coordination programs for most Medicaid-only participants in five mandatory managed care counties, and for the Dual Eligible population in two demonstration areas for the MMAI program. Through these programs HFS surpassed the 50% goal required by law, with an enrollment of over 2 million participants in care coordination programs. The five mandatory managed care regions include Rockford, Central Illinois, Metro East, Quad Cities, and Greater Chicago (Cook and Collar Counties).

1.20 Managed Care Map

Providers are able to view the current expansion map (pdf) on the HFS website. This map shows the programs and Health Plans participating in each county.

1.30 Populations and Programs

Illinois Medicaid Managed Care consists of four programs and within those programs are several Health Plans. Program definitions, populations and participating Health Plans are listed below:

Integrated Care Program (ICP): The Integrated Care Program (ICP) was implemented in May of 2011. ICP is a program for Seniors and Persons with Disabilities who are eligible for the Medicaid program, but not eligible for Medicare. This care delivery system brings together an Enrollee's Providers as an integrated care team to provide a more coordinated medical approach and keep the Enrollee healthier. Integrated care focuses on all of the factors that can affect a person's health and well-being and puts a plan in place to manage all the Enrollee's health needs, whether those needs are physical, behavioral or social.

The ICP program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)
- Rockford (Winnebago, Boone and McHenry counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)
- Metro East (St. Clair, Clinton and Madison counties)
- Quad Cities (Rock Island, Henry and Mercer counties)

To achieve improvements in health, ICP coordinates care between local primary care Physicians, specialists, hospitals, nursing homes, behavioral health Providers and other Providers so that all care is organized around the needs of the enrollee. ICP was phased in as two (2) service packages. It began with the initial rollout of Service Package I for acute health services, such as Physician, hospital and pharmacy services. Service Package II covers Long-Term Services and Supports, including Home and Community Based waiver and Nursing Facility services, and became effective February 1, 2013.

Medicare Medicaid Alignment Initiative (MMAI): The Medicare-Medicaid Alignment Initiative (MMAI) was implemented in March 2014. The MMAI demonstration integrates services covered in Medicare and Medicaid under one managed care program and combines financing streams to eliminate conflicting incentives between the two (2) programs. The overarching goal of MMAI is to integrate benefits to create a unified delivery system that is easier for beneficiaries eligible for both Medicare and Medicaid (Dual Eligibles) to navigate. HFS and federal Centers for Medicare and Medicaid Services (CMS) contracted with eight (8) Health Plans to assume financial risk for the care delivered to Dual Eligible participants with responsibilities for robust care coordination efforts where performance will be measured and tied to quality measurement goals. MMAI is a voluntary program with passive enrollment.

The MMAI program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)

Family Health Plans/ACA Adults (FHP): Family Health Plan (FHP)/Affordable Care Act (ACA) program is a mandatory managed care program for the Family Health population and the newly eligible ACA adults. HFS began mandatory enrollment in the summer of 2014. Under this expansion effort, individuals enrolled in the Illinois Health Connect program or with a Voluntary Health Plan, and newly eligible ACA adults, started the process of enrolling with a Health Plan for their health care delivery. HFS has nine (9) contracted Health Plans in the FHP/ACA program.

The FHP program operates in the following regions:

- Greater Chicago (Cook, DuPage, Kane, Kankakee, Lake and Will counties)

- Rockford (Winnebago, Boone and McHenry counties)
- Central Illinois (Knox, Stark, Peoria, Tazewell, McLean, Ford, Menard, Logan, Sangamon, Christian, Mason, Piatt, DeWitt, Champaign and Vermilion counties)
- Metro East (St. Clair, Clinton and Madison counties)
- Quad Cities (Rock Island, Henry and Mercer counties)

Illinois Health Connect (IHC): The Illinois Health Connect (IHC) program was the Department's first step toward implementing managed care throughout the State. During 2014 and 2015, the majority of participants previously enrolled in IHC joined managed care Health Plans for their care coordination services. IHC remains a choice for participants in the non-mandatory managed care regions; however, it is not a choice for participants statewide. To obtain more information regarding IHC, Providers are directed to the IHC website.

Health Plans and the Programs in Which They Participate:

MCOs	ICP	MMAI	FHP/ACA
Aetna Better Health	X	X	X
Blue Cross Blue Shield of Illinois	X	X	X
Community Care Alliance of Illinois (CCAI)	X		
CountyCare	X		X
Family Health Network (FHN)			X
Harmony Health Plan			X
Health Alliance Connect	X	X	X
HealthSpring	X	X	
Humana	X	X	
IlliniCare	X	X	X
Meridian Health Plan of Illinois	X	X	X
Molina Healthcare	X	X	X
NextLevel Health	X		X

1.40 Participant Enrollment

The majority of Medicaid participants are required to enroll in a managed care program. The Illinois Participant Enrollment Services (ICES), Maximus, conducts all enrollment activities for the Department. Based on the eligibility data provided to the ICES by the Department, the ICES will determine which managed care program is appropriate for the participant and mail an initial enrollment packet to the participant's address on file with the Department. The enrollment packet details the Health Plan choices available to the participant and the date by which the participant must respond with a voluntary choice. The initial enrollment packet is followed by a second enrollment packet approximately 30 days later. The second enrollment packet details the Health Plan and a Primary Care Provider (PCP) to whom the participant will be assigned if a voluntary choice is not made by the given response date. The Department encourages participants, their families, or their authorized representatives to make an active choice of a Health Plan since those individuals know the participant's health care needs best.

If a voluntary enrollment is not received by the response date, the ICES will utilize an advanced algorithm to assign the participant to a Health Plan and a PCP. The algorithm considers past Provider relationships and claims history to assign participants to a "best fit" Health Plan and PCP. As a last resort, geo-mapping is used to assign a participant to a Health Plan and PCP within certain specified travel/distance parameters.

For programs that utilize a lock-in period (Family Health and Integrated Care), the ICES will conduct similar enrollment activities for participants during their annual Open Enrollment period. Participants who are required to enroll in a managed care program can do so in one of two ways. Participants (other than those enrolling in the Medicare-Medicaid Alignment Initiative) can enroll via the Internet at the ICES website. All participants may enroll by contacting the ICES at this toll-free number: 1-877-912-8880 (TTY: 1-866-565-8576).

1.50 Provider and Health Plan Participant Education at Provider Locations

If a Provider chooses to educate their patient at their Provider location(s), Providers and their staff must ensure that the patient is aware of all plan choices and use materials approved by the Department for this education. A flyer/letter template is available to Providers to use in their offices which will require the Provider to include all Health Plans with whom they are contracted. The flyer/letter template (pdf) is available on the HFS website.

If a Provider chooses to prefer a Health Plan in the flyer/letter (the preference must be a benefit to the participant, not only to the Provider), Providers may add a paragraph to the flyer/letter indicating their preference. The paragraph must make no false or disparaging statements about other Health Plans and must be presented in a positive way. Any flyer/letter that has a preferred Provider paragraph must be submitted through the preferred Plan for HFS approval.

The Provider template flyer/letter, including those with a preferred Health Plan paragraph must have a statement at the bottom that states, "To learn more about your Health Plan choices please contact Illinois Participant Enrollment Services (ICES) at 1-877-912-8880 or visit the ICES website".

Provider offices may provide a phone for their patients to contact the ICES directly to enroll. Online enrollment is prohibited within any Provider settings, health fairs, etc. This includes all Health Plan Primary Care Provider offices.

Chapter 2 Provider Relations

2.10 Provider Enrollment

Provider enrollment in Medicaid Managed Care consists of a two part process. The first is to enroll with the Illinois Medical Assistance Program (Medicaid) and subsequently receive approval from the State to be a participating Provider in the program. The second is to contract with each Health Plan in which you want to participate. Contracting with a Health Plan does not automatically guarantee enrollment into Medicaid, as Medicaid enrollment is a separate process.

2.20 Enrollment into Medicaid

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented an electronic Provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

To obtain more information and/or to enroll in IMPACT, Providers are directed to the IMPACT website.

The effective date of enrollment for the eligible Provider will be established upon final approval of the application by the Department. Payment will not be made for services rendered prior to the effective date of enrollment. Change in ownership or corporate structure necessitating a new federal tax identification number terminates the participation of the enrolled Provider. Participation approval is not transferable. Claims submitted by the new owner using the prior owner's assigned Provider number may result in recoupment of payments and other sanctions.

In preparation for the enrollment process Providers should:

- **Obtain a National Provider Identifier (NPI) number**. The federal government requires that Providers who administer "medical and other health services" should obtain an NPI number – a unique 10-digit identification number for covered health care Providers. For more information visit the federal CMS HIPAA webpage.
- **Renew any professional certifications or licensures.** Current certification or licensure is a condition of participation in the Medicaid Program. If your profession requires a certification or licensure in the State of Illinois, these qualifications must be active at the time of enrollment or revalidation. This includes the Clinical Lab Improvement Amendments Certification, administered by the Illinois Department of Public Health Office of Health Care Regulation.
- **Submit a current W9 to the Illinois State Comptroller for certification**. Be sure it is current, as the comptroller does not accept copies of older versions. This W9 should have the tax number that you intend to be paid under.
- **Decide on an email address**. Your email address is used for communication with the state as this will be the primary mode of communication and will be required in order to complete the enrollment process.

2.30 Enrollment into a Health Plan

Enrollment into a Health Plan is a three step process: contracting, credentialing and Provider load.

1. Contracting. Contact any Health Plan you are interested in contracting with by reaching out to the Provider Network representative on the Health Plan contact list (pdf).
2. Credentialing. In addition to contracting with the Health Plan, Providers must be credentialed by the Health Plan. Credentialing takes approximately thirty (30) to ninety (90) days. It is imperative for Providers to submit clean documents with all applicable information when submitting their credentialing applications.
3. Provider Load. Once a Provider is credentialed, it takes thirty (30) to sixty (60) days to load Provider information into the Health Plan's system.

2.40 Provider Contracting

Medicaid Providers located in or near the mandatory regions are encouraged to contract with one or more of the Health Plans (pdf) to become part of their network(s). The contract negotiated between the Medicaid Provider and the Medicaid Health Plan dictates the relationship between the two parties, including payment provisions, prior authorization requirements, utilization review requirements, Provider Complaint and resolution procedures and panel limitations. Once a Provider has contracted successfully with a Health Plan, the Provider is considered an Affiliated Provider.

2.50 Provider Training

Health Plans are required to meet with the Affiliated Provider and/or the Provider's staff to explain their policies and procedures. Provider orientation or training will include information on the Health Plan's utilization policies and procedures, cultural competency requirements, and billing or claims submittal information in order to be reimbursed for a service rendered. A contact person at the Health Plan will serve as the Provider's representative. These sessions are held via phone call, webinar or in the Providers' offices. The Health Plans and the Department developed a Provider Training Attestation form (pdf), which allows Providers to document that they have already been trained in a particular area from a specific Health Plan, so they aren't taking the same course repeatedly for each Health Plan. The Health Plans have the Provider complete the attestation form and the Health Plan must keep the form on file for auditing purposes.

In most instances Health Plans establish their own utilization and prior authorization requirements which may or may not coincide with the requirements the Department has in place under Fee-For-Service. Health Plans may also establish, via Provider subcontracts, different timely filing requirements than the Department. These are examples of processes that will be explained during a Provider's orientation.

Provider manuals are available online to all Affiliated Providers. Each Health Plan has a Provider portal where the Provider can go to learn administrative and referral requirements and to make a request for prior authorization. The Provider directory (pdf) is also available to Providers online.

If a Provider has a dispute over a claim, the Health Plan will address that dispute through their Complaint and resolution system.

The Department has issued several Provider notices regarding managed care and working with and coordinating care with these organizations. The Health Plans are encouraged to sign up for all Provider notices in order to remain informed of information the Department is providing to all enrolled Medicaid Providers. The Health Plans are also made aware of policy changes and rate changes through Provider notices as well.

2.60 Provider Billing

Providers are responsible to bill the Health Plan directly for Health Plan Enrollees. Every Health Plan's Enrollee ID card contains the Enrollee's HFS RIN. Providers MUST verify coverage and Health Plan enrollment through one of the HFS automated systems using the participant's Social Security Number or the participant's RIN found on either the HFS Medical Card or Health Plan's Enrollee ID card.

It is critical that Providers check the Department's electronic eligibility systems regularly to determine a participant's enrollment in a Health Plan. The three options are: 1) Recipient Eligibility Verification Program (REV); 2) the Medical Electronic Data Interchange (MEDI) system; or 3) the Automated Voice Response System (AVRS) at 1-800-842-1461.

Using REV and MEDI to Determine a Participant's Health Plan

Recipient Eligibility Verification (REV) programs and MEDI identify the name of the Health Plan for Medicaid participants enrolled in a Health Plan. Providers must bill the Health Plan for Health Plan Enrollees.

Using the AVRS to Determine a Participant's Health Plan

Providers can get Participant eligibility information by calling 1-800-842-1461, the Automated Voice Response System (AVRS). To check eligibility on AVRS, Providers will need the:

- 9-, 10- or 12-digit Medicaid Provider number;
- 9-digit Recipient Identification Number (RIN); and
- Date for which eligibility information is being sought.

The AVRS will provide all information relating to a Participant's eligibility, including Health Plan enrollment, and will permit up to 6 eligibility inquiries during each telephone call.

The Department pays the Health Plans on a full-risk capitated basis to cover the cost of Medicaid services and care coordination. Providers must provide services in accordance with each Health Plan's utilization policies and procedures, including procedures for prior

authorization and billing. All questions, including billing questions, should be directed to the Health Plans.

2.70 Encounter Data

If a Provider is paid on a capitated basis, it is imperative that the Provider submits Encounter Data to the Health Plan. If no claim is received, and submitted to the Department by the Health Plan, there is no record of services. Records of services help the Department monitor quality and continue to develop accurate rates for the Health Plans.

2.80 Timely Payment

Health Plans are responsible for making payments to Providers for covered services on a timely basis consistent with the Claims Payment Procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a.

- Health Plans must pay 90 percent (90%) of all clean claims from Providers for covered services within thirty (30) days following receipt.
- Health Plan must pay 99 percent (99%) of all clean claims from Providers for covered services within ninety (90) days following receipt.

Note: A “clean claim” is a claim from a Provider for covered services that can be processed without obtaining additional information from the provider of the service or from a Third Party, except a claim submitted by or on behalf of a Provider who is under investigation for Fraud or Abuse, or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee’s admission to a Nursing Facility, a “clean claim” means that the admission is reflected on the patient credit file that Health Plan receives from the Department.

2.90 Reimbursement

Health Plans are responsible for making payments as required under their contract with the Provider. Exclusions to this rule are listed below:

- **Emergency Services.** Health Plans must pay at least the Department’s rate for appropriate Emergency Services provided by a Non-Affiliated Provider.
- **Post Stabilization Services.** Health Plan must pay a least the Department’s rate for all Post-Stabilization Services as a covered service in any the following situations:
  - Health Plan authorized such services;
  - Such services were administered to maintain the Enrollee’s Stabilized condition within one (1) hour after a request to the Health Plan for authorization of further Post-Stabilization Services; or
  - Health Plan did not respond to a request to authorize such services within one (1) hour, Health Plan could not be contacted, or, if the treating Provider is a Non-Affiliated Provider, Health Plan and the treating Provider could not reach an agreement concerning the Enrollee’s care and an Affiliated Provider was unavailable for a consultation. In such case, the Health Plan must pay for services rendered by

the treating Non-Affiliated Provider until an Affiliated Provider was reached and either concurred with the treating Non-Affiliated Provider's plan of care or assumed responsibility for the Enrollee's care. Such payment shall be made at the same rate the Department would pay for such services according to the level of services provided and exclusive of disproportionate share payments and Medicaid percentage adjustments.

- **Family Planning Services.** Health Plan must pay for family planning services rendered by a Non-Affiliated Provider, for which the Health Plan would pay if rendered by an Affiliated Provider, at the same rate Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments, unless a different rate was agreed upon by Health Plan and the Non-Affiliated Provider.

If a Provider is having billing problems they should follow up with the managed care representative that was assigned to them for contracting. Provider Complaints must be filed with the Health Plan.

2.100 Provider Complaint Resolution

Health Plans must maintain a complaint and resolution process for providers. If a provider disagrees with a policy, decision, or procedure, the provider should follow the Health Plan provider complaint process. Health Plans are required to make every effort to resolve any Provider Complaints. All disputes are handled between the Health Plan and the provider, unless the Health Plan has not fulfilled its duties under the applicable State Contract.

2.110 Non-Affiliated Providers

Providers who are not contracted with a Health Plan should not provide non-emergency services to Health Plan Enrollees unless they receive a prior authorization from the Health Plan. There are some services that do not require a Non-Affiliated Provider to receive prior authorization, including:

- **Emergency Services.** Health Plan members may access affiliated or Non-Affiliated Providers for appropriate Emergency Services.
- **Post-Stabilization Services.** Post-Stabilization Services are provided under certain situations, including:
  - The Health Plan authorizes such services;
  - Such services are administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the Health Plan for authorization of further Post-Stabilization Services; or
  - The Health Plan does not respond to a request to authorize further Post-Stabilization Services within one (1) hour; the Health Plan cannot be contacted, or the Health Plan and the treating Non-Affiliated Provider cannot reach an agreement concerning the Enrollee's care and an Affiliated Provider is unavailable for a consultation. In such case, the treating Non-Affiliated Provider must be permitted to continue the

care of the Enrollee until an Affiliated Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.

- **Family Planning Services.** Family Planning is a direct access service. Health Plans provide coverage of family planning services for all Enrollees whether the family planning services are covered by an affiliated or Non-Affiliated Provider.
- **School-Based Health Centers.** Under the Family Health Plan Program, Health Plans will accept claims from Non-Affiliated Providers of school health center services outside of the Health Plan's contracting area. Payments of such services will be according to the HFS applicable Medicaid Fee-For-Service reimbursement schedule. Health Plans may require the Non-Affiliated Providers of school health centers to follow its protocols for communication regarding services rendered in order to further care coordination.
- **School Dental Program.** Under the Family Health Plan Program, Health Plans will accept claims from Non-Affiliated Providers of dental services provided in a school for Enrollees under the age of 21 outside of the Health Plans contracting area. Payments of such services will be according to the HFS applicable Medicaid Fee-For-Service reimbursement schedule. Health Plans may require the program to follow its protocols for communication regarding services rendered in order to further care coordination.
- **SASS Services.** Screening, Assessment and Support Services (SASS) program is a statewide program resulting from the Children's Mental Health Act of 2003, which requires the Department to ensure that all eligible children and adolescents receive a screening and assessment prior to any admission to a hospital for inpatient psychiatric care. With the passage of this Act, the Department joined forces with two other Illinois State departments that have been funding screening and assessment services for children and adolescents since 1992 - the Department of Human Services (DHS) and Department of Children and Family Services (DCFS) - to create a coordinated single-point of entry for children and adolescents in need of mental health services. This system is designed to be a family-friendly unified system that will reduce fragmentation in service delivery. Under the Family Health Plan Program, Health Plans will accept claims from a Non-Affiliated Provider of SASS services in the event that an Enrollee is screened, due to necessity, by such Non-Affiliated Provider. The Health Plan will pay for such screening at the Medicaid rate.

Health Plans will accept claims from Non-Affiliated Providers for at least six (6) months after the date the services are provided. Non-Affiliated Providers must be enrolled in the HFS Medical Program prior to receiving payment for services rendered to Illinois Medicaid participants including those enrolled in a Health Plan.

Chapter 3 Care Coordination

3.10 Care Coordination

Health Plans are responsible for offering Care Management through a Care Coordinator who participates in an Interdisciplinary Care Team (ICT) for all medical, behavioral health, functional, and psychosocial needs, as appropriate, to address the needs and preferences of the Enrollee. The higher the risk of the Enrollee, the higher the level of care coordination provided by the MCO.

3.20 Interdisciplinary Care Team

Health Plan's Care Coordinator's may be in touch with Providers to invite them to participate in an Enrollee's Interdisciplinary Care Team (ICT). The Care Coordinator forms an ICT with the help of the Enrollee. The ICT is person centered and is to build on each Enrollee's specific preferences and needs. Each ICT consist of clinical and non-clinical staff whose skills and professional experience will complement and support each other in the oversight of each Enrollee's needs. The Enrollee's PCP is an important part of the health team involved in the coordination and direction of services for the Enrollee. The Care Coordinator provides the PCP with reports, updates, and information regarding the Enrollee's progress through the Care Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

ICT meetings are not necessarily formal and face to face. Providers can participate by phone, through emails, faxes, etc. Anyway the Provider can participate in the Enrollees overall health care goals is a benefit for the Enrollee.

3.30 Care Plans

The ICT led by the Care Coordinator is responsible for developing a comprehensive person-centered Enrollee Care Plan. The Enrollee Care Plan incorporates an Enrollee's medical, behavioral health, social, and functional needs. Providers, as part of the ICT, are welcome to participate in the development of the care plans.

3.40 Service Plans as Part of the Care Plan

Enrollees receiving Home and Community Based Waiver services have Service Plans, which include information on areas of assistance Enrollees need to keep them safe and residing in their homes. Service Plans are a component of the Care Plan. For example, a Service Plan might contain information on grooming, bathing, housework, and/or meal preparation, and the Service Plan will include how much time a service agency or assistant might need to help Enrollees complete these tasks.

There are three distinct time frames for Health Plans to have a Service Plan, new or existing, in place:

- Service Plans are developed within 15 days of the Health Plan being informed from a State agency that an Enrollee is eligible for Home and Community Based Waiver services.
- Service Plans remain in place for 180 days for an Enrollee who has an existing Service Plan but is new to the Health Plan (Enrollee came from Fee-for-Service).
- Service Plans remain in place for 90 days for an Enrollee who is transferring from one Health Plan to another Health Plan.

The Health Plans will update the Service Plan as an Enrollee's need changes.

3.50 Transition of Care

Health Plans are responsible for any covered services necessary to treat medical conditions that existed before the participant enrolled with the Health Plan. As long as an Enrollee is in an existing course of treatment, the service is a covered service, and the service is Medically Necessary, the Health Plan will support the continuation of that service.

Health Plans are responsible for the on-going course of treatment, also called continuity of care, when a new Enrollee joins the Health Plan while in the middle of actively receiving treatment from a Provider.

- In the Integrated Care Program and the Family Health Plan Program, a Non-Affiliated Provider can continue to treat the Enrollee for an initial 90-day transition period or through the postpartum period. To do so, the Non-Affiliated Provider must agree to accept reimbursement from the Health Plan at the Health Plan's established rates, follow the Health Plan's Quality Assurance requirements, and agree to follow the Health Plan's policies and procedures. This includes the Health Plan's referral and authorization requirements.

- In the Medicare Medicaid Alignment Initiative (MMAI), a Non-Affiliated Provider can continue to treat the Enrollee for an initial 180-day transition period. When the MMAI Enrollee switches from one Health Plan to another, the new Health Plan will offer a 90-day transition period. To do so, the Non-Affiliated Provider must agree to accept reimbursement from the Health Plan at the Health Plan's established rates, follow the Health Plan's Quality Assurance requirements, and agree to follow the Health Plan's policies and procedures. This includes the Health Plan's referral and authorization requirements.

Health Plans also have special transition of care requirements for their LTSS population. LTSS Enrollees are Enrollees residing in a nursing home or receiving Home and Community Based Service waivers (HCBS).

All individuals receiving HCBS have a Service Plan that addresses all identified needs for services received at home. If an Enrollee was receiving HCBS services before becoming enrolled in the Health Plan, that existing Service Plan must remain in effect for at least 180

days. The Health Plan can only change the Service Plan within the 180 days if the Enrollee provides input and agrees to the change.

Chapter 4 Covered Services

The Health Plans are required to cover almost all services offered under Illinois Medicaid. They can also provide services beyond those covered under Medicaid, but Health Plans do so at their own expense. These additional services are approved by the Department before being offered to their members. The monthly Capitation payment the Health Plans receive from the Department for each of their members is based on Medicaid services, not the additional services they choose to offer.

4.10 Service Package I Covered Services

A list of Medicaid services can be found in 89 Ill. Adm. Code, Part 140. The list of covered services, often referred to as Service Package 1, include:

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Assistive/Augmentative communication devices;
- Audiology services;
- Blood, blood components and the administration thereof;
- Chiropractic services for Enrollees under age twenty-one (21);
- Dental services, including oral surgeons;
- EPSDT services for Enrollees under age twenty-one (21) pursuant to 89 Ill. Admin. Code Section 140.485, excluding shift nursing for Enrollees in the MFTD HCBS Waiver for individuals who are Medically Fragile and Technology Dependent (MFTD);
- Family planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital emergency room visits;
- Hospital inpatient services; Hospital ambulatory services;
- Laboratory and x-ray services (Health Plan shall receive and transmit electronic lab values to support clinical management and for HEDIS® reporting);
- Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies;
- Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option;
- Nursing care for Enrollees under age twenty-one (21) not in the HCBS Waiver for individuals who are MFTD, pursuant to 89 Ill. Admin. Code Section 140.472;

- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Enrollees under age twenty-one (21), pursuant to 89 Ill. Admin. Code 146, Subpart D;
- Nursing Facility services for the first ninety (90) days (NF services 91+ days included in Service Package II);
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy Services (drugs used in the treatment of Hepatitis C are covered only if dispensed in accordance with Health Plan's coverage criteria approved by the Department);
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services for Enrollees under age 21;
- Podiatric services for diabetic Enrollees age 21 and over, and, effective October 1, 2014, podiatric services for all Enrollees age 21 and over;
- Post-Stabilization Services;
- Renal Dialysis services;
- Respiratory Equipment and Supplies;
- Services to prevent illness and promote health in accordance with Attachment XXI
- Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390, 77 Ill. Admin. Code Part 2090, Day treatment (residential) and Day treatment (detox);
- Transplants, pursuant to 89 Ill. Admin. Code Section 148.82 (using transplant Providers certified by the Department); and
- Transportation to secure Covered Services.

4.20 Pharmacy Services

Health Plans are required to cover drugs. They must cover all drugs covered by Medicaid, but it does not have to be the exact same set of drugs. The Health Plan's formulary cannot be any more restrictive than the Department's list of covered drugs. The Department reviews and prior approves the Health Plan's formularies.

4.30 Hospice Services

Health Plans are required to cover Hospice Services. Hospice Providers are required to complete a Medicaid Hospice Benefit Election Form (HFS 1592) (pdf) for hospice members.

Hospice Providers must submit this form to both HFS and also send a copy of the form to the Health Plan of the Enrollee.

4.40 Dental Services

Dental services are provided through the Health Plans and the dental Provider must bill the appropriate Health Plan's dental administrator to receive payment. Some Health Plans offer additional dental benefits to their members above the basic Medicaid program benefit.

4.50 Emergency and Non-Emergency Transportation

All non-emergency transportation services for Health Plan Enrollee's must be prior approved by the Health Plan when transport is needed for medical services covered by the Health Plan. To obtain prior approval for non-emergency transportation for Health Plan Enrollees, the Health Plan must be contacted. The phone number for the Health Plan is printed on the Participant's Health Plan ID card. All Health Plans have medical personnel available 24 hours a day to provide prior approval.

The prior approval/post approval (pdf) form the Health Plans utilize can be found on the First Transit website.

Prior approval from the Health Plan is not required in the following circumstances:

- Emergency services do not require prior approval.
- Participants are not limited to Affiliated Providers for family planning services.

Non-emergency transportation Providers may contest any decision by the Health Plan for which no denial was received prior to the time of transport that either denies a request for approval for payment of non-emergency transportation or grants a request for approval of non-emergency transportation at a level of service that entitles the ground ambulance services Provider to a lower level of compensation than requested by the ground ambulance services Provider.

Health Plans require that Long Term Care Facilities and hospitals utilize a uniform certification of medical necessity for non-emergency ambulance transportation except where it is reasonable to believe a delay in transportation can be expected to negatively affect the efficient transportation.

4.60 Behavioral Health

Behavioral health services include both mental health and substance abuse. Health Plans are required to cover both services, including services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option.

Some Health Plans have a subcontractor specializing in providing Behavioral Health services. Health Plans can create their own prior authorization and utilization requirements surrounding behavioral health.

Health Plans require each Affiliated Provider that provides services under a DHS HCBS Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or members receiving alcoholism and substance abuse treatment services to continue entering data about that Enrollee into DHS' system. This includes the DHS Automated Reporting and Tracking System (DARTS). This is a requirement under State rules.

4.70 Service Package 2 Covered Services

Health Plans are also responsible for all Service Package 2 services, which includes Nursing Home services and Home and some Community Based Waiver Services (HCBS). These are also called Long Term Supports and Services (LTSS).

4.80 HCBS Services

Illinois has nine (9) HCBS waivers. Different State agencies operate the waivers, with HFS overseeing the operation of each waiver. Each waiver is designed for individuals with similar needs and offers a different set of services. Waiver programs are approved by Federal CMS and allow Illinois to cover a broad range of services to allow individuals to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting.

While Illinois offers nine HCBS waivers, only five of the nine are considered part of Service Package 2 and therefore the Health Plans are responsible to arrange and pay for the services under these five waivers. Waivers designed for individuals with Developmental Disabilities are excluded from managed care.

Please note that for the Integrated Care Program and the Family Health Plan Program, individuals enrolled in the Developmental Disabilities waivers are enrolled in managed care for their medical coverage; it is their HCBS waiver services that are excluded and remain under Fee-For-Service.

Under the Medicare Medicaid Alignment Initiative, individuals enrolled in the Developmental Disabilities waivers are excluded from managed care. Children in the Medically Fragile Technology Dependent waiver are excluded from all managed care programs.

Health Plans are only allowed to use HCBS Providers that have been approved and authorized by the State agency in charge of that particular waiver. If a Provider, for example, is only approved by the Illinois Department on Aging to provide HCBS services to those on the Elderly waiver, that Provider is not allowed to provide the same services to members of the Persons with Disabilities waiver. The Provider must first be approved and authorized to provide services under the other waiver(s). The Health Plans do not credential HCBS waivers.

Health Plans are required to pay HCBS Providers at least the Medicaid rate for providing HCBS services. They cannot pay less than what Medicaid offers for these services.

Providers who think managed care members might benefit from HCBS services can refer those members at any time. They can contact the Enrollee's Care Coordinator and suggest an assessment be completed to determine if the Enrollee is eligible for HCBS services. Providers can also refer their members through these websites:

- Rehabilitation Services (to refer members for the Persons with Disabilities, Brain Injury, or HIV/AIDS waiver)
- Senior HelpLine (To refer members for the Elderly waiver)
- Supportive Living Facilities (to refer members for the Supportive Living Program)

All individuals residing in a Nursing Facility or receiving HCBS waiver services receives care coordination from their Health Plan. Care Coordinators who work with the HCBS population must meet certain educational and training criteria. Care Coordinators must also maintain frequent contact with their HCBS and Nursing Facility Enrollees. Those contact requirements are included below in the description of each waiver.

Below is a brief description of the five (5) waivers that are covered by Health Plans under Service Package 2:

1. **HCBS Waiver for Persons who are Elderly.** The Department on Aging (DoA) is the operating agency for the HCBS waiver for persons who are elderly, which is part of the Community Care Program (CCP). The CCP offers services to persons age 60 and over who meet functional and financial eligibility criteria. Examples of services received under the Elderly waiver include Adult Day Care, Homemaker services, and/or the Personal Emergency Response System. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every 90 days.
2. **HCBS Waiver for Assisted Living, Supportive Living Program.** HFS is the operating agency for the Supportive Living Program. The Supportive Living Program serves persons age 65 and older or persons age 22 to 64 who have physical disabilities. A Supportive Living Facility (SLF) is a Department-approved residential setting in Illinois. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every year.
3. **Persons with Disabilities Waiver.** The DHS Division of Rehabilitation Services (DHS-DRS) is the operating agency for this waiver, which serves individuals between the ages of birth through 59 years, unless the individual was receiving services prior to the 60th birthday and chose to remain in the waiver. The person must have a medical determination of a diagnosed, severe disability, which is expected to last for at least 12 months or for the duration of life. Examples of services received under the Persons with Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for members enrolled in this waiver must meet with the Enrollee face-to-face at least once every 90 days.
4. **Persons with HIV/AIDS Waiver.** DHS-DRS is the operating agency for this waiver, which serves persons with HIV/AIDS of any age who have a medical determination of HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life. Examples of services received under the Persons with

Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for Enrollees in this waiver must meet with the Enrollee face-to-face at least once every two months.

5. **Persons with Brain Injury Waiver.** DHS-DRS is the operating agency for this waiver, which serves persons with brain injury of any age who have an acquired brain injury. Examples of services received under the Persons with Disabilities waiver includes Personal Assistants, Adult Day Care, Environmental Accessibility Adaptations, additional therapy services, Home Delivered Meals, Homemaker services, and/or Personal Emergency Response System. Health Plan Care Coordinators for Enrollees in this waiver must meet with the Enrollee face-to-face at least once every month.

Participant direction of services is an important component of HCBS services. The Department expects that the Enrollee will continue to have the authority to exercise decision-making authority over some or all services and accepts the responsibility for taking a direct role in managing them. Participant direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the Enrollee may be afforded the opportunity and be supported to recruit, hire, and supervise individuals who provide daily supports to them.

4.90 Nursing Facilities Services

Health Plans are also responsible for Long Term Care facility services, including room and board and supervision, equipment and supplies including oxygen, laundry services, food, medications, over-the-counter drugs or items ordered by a Physician. Health Plan Care Coordinators for Enrollee residing in a Nursing Facility must meet with the Enrollee face-to-face at least once every 90 days.

4.100 Non-Covered Services

There are several services that Health Plans are **not** responsible for covering. These services remain Fee-For-Service and should be billed to the Department, not to the Health Plans. These services include:

- Services in a State Facility operated as a psychiatric hospital as a result of forensic commitment
- Services provided through a Local Education Agency (LEA)
- Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund
- Any service considered cosmetic or experimental
- Early Intervention (EI) services

There are also some limitations on covered services including:

- **Termination of pregnancy.** This service can be provided if it meets State and federal law requirements (42 CFR Part 441, Subpart E) and the Provider completes HFS Form 2390 (pdf) after the service is completed. Termination of pregnancy is not a covered service, however, for those eligible under the State Children's Health Insurance Program Act (215 ILCS 106).
- **Sterilization services.** These services can be provided if they meet State and federal law requirements (42 CFR Part 441, Subpart F) with HFS Form 2189 (pdf)completed.
- **Hysterectomy services.** HFS Form 1977 (pdf) must be completed for this service.

Chapter 5 Enrollee Grievance and Appeals

Each Health Plan is required to have an Enrollee Grievance and Appeals policy and procedures established to ensure that actions taken against participants are supported by policy, administrative code and law. The Department serves as a check and balance for managed care companies to make sure participants are receiving covered service to which they are entitled. Medicaid Health Plans are required to establish internal Grievance and Appeals procedures under which Medicaid Enrollees, or an authorized representative acting on their behalf, may make a Complaint, challenge the denial of coverage of, or payment for, covered services. Health Plan Enrollees receive these policies and procedures when they first enroll with the Health Plan in their Enrollee Handbook. The Grievance and Appeals procedures are also listed on each Health Plan's website.

Chapter 6 Quality Assurance Program

Providers must incorporate the delivery of quality care with the primary goal of improving the health status of Enrollees and, where the Enrollee's condition is not amenable to improvement, maintain the Enrollee's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Providers must actively improve the quality of care provided to Enrollees, consistent with its Quality Program, its quality improvement goals, the Department's quality strategy.

6.10 Quality Assurance, Utilization Review and Peer Review

HFS requires that Health Plans, through contacts with the Affiliated Providers, ensure participation in the Health Plans' Quality Assurance Plan (QAP). Health Plan's utilize their Provider services Department representatives to work closely with the Affiliated Providers to ensure they understand the expectations and requirements of participating in the Health Plan QAP.

6.20 Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are utilized to reduce inter-practitioner/Provider variation in diagnosis and treatment. Provider CPG adherence is measured at least annually by the Health Plans. The CPGs are distributed to appropriate practitioners, Providers and Provider groups. The Health Plan determines how the CPGs are disseminated to Providers and this can be through different means including the Provider portal, web or Provider newsletters. The CPGs are available to Providers upon request.

6.30 Preventive Health Guidelines

Preventive Health Guidelines are utilized to provide coverage of diagnostic preventive procedures based on recommendations published by the US Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Guidelines are updated as necessary and distributed to practitioners/Providers via the on-line Provider directory and or the Provider newsletter.

6.40 Cultural and Linguistic Services

HFS serves a diverse Medicaid population with specific cultural needs and preferences. Providers are responsible to ensure that interpreter services are made available at no cost for Medicaid participants with sensory impairment and/or who are Limited English Proficient (LEP).

Providers may request interpreters for members whose primary language is other than English by calling the Health Plan Enrollee services department. If Enrollee services representatives are unable to provide the interpretation services internally, the Enrollee and Provider are immediately connected to language line telephonic interpreter service. For Health Plan's Enrollee Service phone numbers visit the Program Information Guide website.

6.50 Access to Care Standards

HFS requires that Health Plans provide timely access to care for their Enrollees. Providers are required to offer hours of operation no less than hours of operation offered to commercial patients. Access standards are developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available 24 hours-a-day, seven-days-a-week to members. This access may be by telephone. Appointment and waiting-time standards are communicated to the Providers through their contract and they are also listed in the on-line Provider directory.

Appointment Access

No more than six scheduled appointments shall be made for each PCP per hour. Notwithstanding this limit, it is recognized that Physicians supervising other licensed healthcare Providers may routinely account for more than six appointments per hour.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 60 minutes from appointment time, until the time seen by the PCP. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Practitioners are required to maintain a 24-hour phone service, seven days a week. This access can be through an answering service. The service should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. After hours phone calls or pages must be returned within 30 minutes.

At least annually, Health Plans are required to conduct an access audit of randomly selected contracted practitioner/Provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards are not met.

6.60 Site and Medical Record-Keeping Practice Reviews

Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. Health Plans assess the quality, safety and accessibility of office sites where care is delivered. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting- and examining-room space
- Availability of appointments

- Adequacy of medical/treatment record keeping

During the Provider site-visit, Health Plans review office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the medical record information in a consistent manner and include how the practice ensures confidentiality of records.

6.70 Improvement Plans

Providers are required to comply with the Health Plans Quality Improvement Plan (QIP). When compliance is not achieved, the Provider is required to submit a written improvement plan to the Health Plan. This improvement plan must include the expected time frame for completion of activities.

6.80 Measurement of Clinical and Service Quality

HFS requires the Health Plans to monitor and evaluate the quality of care and services provided to Enrollees through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Health Plans are required to collect data to monitor performance with established standards and provide interpretation of these data to its affiliated Practitioners/Providers. Affiliated Providers must allow Health Plans to use its performance data collected in accordance with the Provider's contract. The use of Provider performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers. To see Health Plan's quality measures, visit the Care Coordination website.

Chapter 7 Definitions

Abuse: (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs; (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301).

Action: (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an Health Plan that is the only Health Plan serving a rural area, the denial of an Enrollee's request to obtain services outside of the contracting Area.

Administrative Rules: The sections of the Illinois Administrative Code that govern the Medicaid Program.

Adults with Disabilities: An individual who is 19 years of age or older, who meets the definition of blind or disabled under Section 1614(a) of the Social Security Act (42 U.S.C.1382), and who is eligible for Medicaid.

Advanced Practice Nurse (APN): A Provider of medical and preventive services, including Certified Nurse Midwives, Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners, who is licensed as an APN, holds a valid license in Illinois, is legally authorized under statute or rule to provide services, and is enrolled with the Department and contracted with the Health Plan.

Affiliated Provider: A Provider associated as an employee or by other legally recognizable means with a Health Plan for the purpose of providing services under the Department's contract with the Health Plan.

Anniversary Date: the annual anniversary of an Enrollee's initial enrollment in the Health Plan. For example, if an Enrollee became effective in an Health Plan on October 1, 2010, their Anniversary Date with that Health Plan would be each October 1st thereafter.

Appeal: A request for review of a decision made by the Health Plan with respect to an Action.

CAHPS: Consumer Assessment of Health Plans Survey is a public-private initiative to develop standardized surveys of patient's experience with ambulatory and facility level care.

Capitation: The reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to the Health Plan for the performance of all of the Health Plan's duties and responsibilities.

Care Coordinator: An employee of the Health Plan, together with an Enrollee and Providers, establishes an Enrollee Care Plan for the Enrollee and, through interaction with Affiliated Providers, ensures the Enrollee receives necessary services.

Care Management: Services that assist Enrollees in gaining access to needed services, including medical, social, educational and other services, regardless of the funding source for the services.

Centers for Medicare & Medicaid Services (Federal CMS): The agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (CHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

Complaint: A phone call, letter or personal contact from a Participant, Enrollee, family member, Enrollee representative or any other interested person expressing a concern related to the health, safety or well-being of an Enrollee.

Department or HFS: The Illinois Department of Healthcare and Family Services and any successor agency.

DHS: The Illinois Department of Human Services, and any successor agency.

DHS-DRS: The Division of Rehabilitation Services, and any successor agency, within DHS that operates the home services programs for persons with physical disabilities, brain injury and HIV/AIDS.

DoA: The Illinois Department on Aging, and any successor agency.

Dual Eligible: A Participant who is eligible to receive services through both the Medicare and the Medicaid Program.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services: Those inpatient and outpatient health care services that are covered services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a Provider qualified to furnish Emergency Services.

Encounter: An individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed Fee-For-Service under the Medicaid Program.

Encounter Data: The compilation of data elements, as specified by the Department in written notice, identifying an Encounter that includes information similar to that required in a claim for Fee-For-Service payment under the Department's Medical Program.

Enrollee: A Participant who is enrolled in a Health Plan. "Enrollee" shall include the caretaker relative or guardian where the Enrollee is an adult for whom a guardian has been named; provided, however, that the Health Plan is not obligated to cover services for any individual who is not enrolled as an Enrollee with the Health Plan.

Enrollee Care Plan: An Enrollee-centered, goal-oriented, culturally relevant, and logical, written plan of care that assures that the Enrollee receives medical and medically-related necessary services in a supportive, effective, efficient, timely and cost-effective manner that emphasizes prevention and continuity of care.

Fee-For-Service: The method of charging which bills for each service or encounter rendered.

Fraud: Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Grievance: An expression of dissatisfaction by an Enrollee, including Complaints, about any matter other than a matter that is properly the subject of an Appeal.

Health Plan: A Health Maintenance Organization or a Managed Care Community Network that provides or arranges to provide covered primary, secondary, and tertiary managed health care services for Medicaid Participants under contract with the Illinois Department of Healthcare and Family Services.

Health Insurance Portability and Accountability Act (HIPAA): Also known as the Kennedy-Kassebaum Bill, the Kennedy-Kassebaum Bill, K2, or Public Law 104-191 (pdf), the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides DHHS with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the typesof measures required to protect the security and privacy of personally identifiable health care information.

Home and Community-Based Services (HCBS) Waivers: Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify for the level of care provided in an institution but who, with special services, may remain in their homes and communities.

ILCS: Illinois Compiled Statutes.

Illinois Participant Enrollment Services (ICES): The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices, providing enrollment materials, assisting with the selection of an Health Plan and PCP, and processing requests to change Health Plans.

Integrated Care Program: The program under which the Department will contract with Health Plans to provide the full spectrum of Medicaid covered services through an integrated care delivery system to Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.

Long-Term Care (LTC) Facility or Nursing Facility (NF): A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the counties code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.

Marketing: Any written or oral communication from a healthcare delivery system or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not enroll, or to dis-enroll from a health care delivery system.

Medicaid Program: The program under Title XIX of the Social Security Act that provides medical benefits to groups of low-income people.

Medically Necessary: A service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with the Health Plan's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth.

National Committee for Quality Assurance (NCQA): A private 501(c) (3) not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., Health Plan accreditation.

Neglect: A failure to notify the appropriate health care professional, to provide or arrange necessary services to avoid physical or psychological harm to a resident or to terminate the residency of a Participant whose needs can no longer by met, causing an avoidable decline in function. Neglect may be either passive (non-malicious) or willful.

Non-Affiliated Provider: A Provider who is not associated with a Health Plan for the purpose of providing health care services under a Medicaid managed care program pursuant to a written contract or agreement. Limited service agreements or contracts (e.g. single case agreements) do not constitute network participation.

Nursing Facility (NF): See Long-Term Care Facility.

Older Adult: An individual who is 65 years of age or older and who is eligible for the Medicaid program.

Open Enrollment: The specific period of time each year in which Enrollees shall have the opportunity to change from one Health Plan to another Health Plan.

Participant: Any individual determined to be eligible for the Medicaid Program.

Performance Measure: A quantifiable measure to assess how well an organization carries out a specific function or process.

Person: Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, contractor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

Personal Assistant: Individuals who provide Personal Care to a Participant when it has been determined by the Care Coordinator that the Participant has the ability to supervise the Personal Care Provider.

Personal Care: Assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of a Participant.

Personal Emergency Response System (PERS): An electronic device that enables a Participant at high risk of institutionalization to secure help in an emergency.

Physician: means an individual licensed to practice medicine in all its branches in Illinois under the Medical Practice Act of 1987 or any such similar statute of the state in which the individual practices medicine.

Post-Stabilization Services: Medically necessary non-emergency services furnished to an Enrollee after the enrollee is stabilized following an Emergency Medical Condition, in order to maintain such stabilization.

Potential Enrollee: A Participant who is subject to mandatory enrollment in a managed care program, but is not yet an Enrollee of a Health Plan.

Primary Care Provider (PCP): A Provider, including a WHCP, who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to assigned Enrollees in the Health Plan.

Provider: A Person enrolled with the Department to provide Covered Services to a Participant.

Quality Assurance (QA): A formal set of activities to review, monitor and improve the quality of services by a Provider or Health Plan, including quality assessment, ongoing quality improvement and corrective actions to remedy any deficiencies identified in the quality of direct Enrollee, administrative and support services.

Quality Assurance Plan (QAP): A written document developed by the Health Plan in consultation with its QAP committee and Medical Director that details the annual program goals and measurable objectives, utilization review activities, access and other Performance Measures that are to be monitored with ongoing Physician profiling and focus on quality improvement.

Quality Program: The Health Plan’s overarching mission, vision and values, which through its goals, objectives and processes committed in writing in the QAP, are demonstrated through continuous improvement and monitoring of medical care, Enrollee safety, behavioral health services, and the delivery of services to Enrollees, including ongoing assessment of program standards to determine the quality and appropriateness of care, Case Management and coordination. It is system-wide and implemented through the integration, coordination of services, and resource allocation throughout the organization, its partners, Providers, other entities delegated to provide services to Enrollees, and extended community involved with Enrollees.

Recipient Identification Number (RIN): The nine-digit identification number unique to the individual receiving coverage under one of the Department’s Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Service Plan: A plan that addresses all identified needs for services received at home.

Significant Change: A decline or improvement in a Participant’s status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical

interventions, where the decline or improvement impacts more than one area of the Participant’s health status and requires revision of the Enrollee Care Plan.

Skilled Nursing: Nursing services provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

Skilled Nursing Facility (SNF): A group care facility that provides Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing and other services under professional direction with frequent medical supervision, during the post-acute phase of illness or during reoccurrences of symptoms in long-term illness.

Speech Therapy: A medically prescribed speech or language based service that is provided by a licensed speech therapist and identified in the Enrollee Care Plan that is used to evaluate or improve an Enrollee's ability to communicate.

Stabilization or Stabilized: A determination with respect to an Emergency Medical Condition made by an attending emergency room Physician or other treating Provider that, within reasonable medical probability, no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

State: The State of Illinois, as represented through any agency, department, board, or commission.

Supportive Living Facility (SLF): A residential apartment-style (assisted living) setting in Illinois that is certified by the Department that provides or coordinates flexible Personal Care services, twenty-four (24) hour supervision and assistance (scheduled and unscheduled), activities, and health related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and references; has an organizational mission, service programs and physical environment designed to maximize residents’ dignity, autonomy, privacy and independence; and encourages family and community involvement.

Third Party: Any person other than the Department, Health Plan, or any of Health Plan's affiliates.

Long Term Supports and Services (LTSS): Nursing home services or Home and Community Based Service waivers (HCBS) services.

Chapter 8 Links

Internet Site
Illinois Department of Healthcare and Family Services
Administrative Rules
All Kids Program
Care Coordination
Claims Processing System Issues
Child Support Enforcement
FamilyCare
Family Community Resource Centers
Health Benefits for Workers with Disabilities
Health Information Exchange
Home and Community Based Waiver Services
Illinois Health Connect
Illinois Veterans Care
Illinois Warrior Assistance Program
Maternal and Child Health Promotion
Medical Electronic Data Interchange (MEDI)
State Chronic Renal Disease Program
Medical Forms Requests
Medical Programs Forms
Non-Institutional Provider Resources
Pharmacy Information
Provider Enrollment Information
Provider Fee Schedules
Provider Handbooks
Provider Notices
Registration for E-mail Notification
Place of Service Codes
Centers for Medicare and Medicaid Services (CMS)